MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC

Response Timely Filed? ( ) Yes (X) No

Requestor's Name and Address
Surgical and Diagnostic Center, LP
729 Bedford Euless Road West, Suite 100
Hurst, Texas 76053

RECEIVED
AUG 12 2005
FLAHIVE, OGDEN & LATSON
ANITA DRAKE

Respondent's Name and Address
American Home Assurance Company
C/o Flahive, Ogden & Latson
Box 19

MDR Tracking No.: M4-03-8254-01
TWCC No.: [redacted]
Injured Employee's Name: [redacted]
Date of Injury: [redacted]
Employer's Name: [redacted]
Insurance Carrier's No.: [redacted]

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
07/23/02	07/23/02	29881—Arthroscopy, knee	$2,610.26	$0.00
07/23/02	07/23/02	80005—Lab Fees	$44.00	$0.00
07/23/02	07/23/02	86311—Lab Fees	$50.00	$0.00
07/23/02	07/23/02	93005—Lab Fees	$35.00	$0.00
07/23/02	07/23/02	93010—Lab Fees	$15.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Surgical and Diagnostic Center contends that the fee paid was not fair and reasonable because it is below the amount the majority of the other insurance carriers are reimbursing and does not take into account all of the supplies and medications to treat this patient, the amount of time spend in the operating room and other costs. The fee paid does not ensure effective medical cost control because it does not properly compensate for items specifically needed by and provided to the patient.

PART IV: RESPONDENT'S POSITION SUMMARY

According to Rule 1344.401 (a)(4), no fee exists for ambulatory surgical care, and services are to be paid at a fair and reasonable rate until the issuance of a fee guideline.....The carrier, in determining what constitutes a "fair and Reasonable rate" did consider the Medicare, PP and HMO payments and reviewed the Commission's own guidelines for acute care. Acute Care Guidelines state that $1118.00 is a valid reimbursement of a full day of inpatient care, or approximately 24 hours. By definition, outpatient or ambulatory services are those that require less than 90 minutes anesthesia time and less that four hours of recovery. This means the patient receives care from the facility for 1/4th of the time of being in an inpatient setting for a full day, and the facility is paid at the equivalent of a one day inpatient stay. The Acute Care Fee Guidelines were used as a consideration in determining reimbursement—however, this does not mean that inpatient guidelines were applied to this service.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 173.9% to 226.5% of Medicare for this particular year). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, the original reimbursement on these services is within the low end of the Ingenix range. Lab fees are included in the facility fees and are not separately payable. The decision for no additional reimbursement was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the decision and discussed the facts of the individual case.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Findings and Decision by:

Debra Hausenfluck	Debra Hausenfluck	August 5, 2005
Authorized Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on 8-10-05. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____